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Q. Which is a total of three areas?
A. Correct.
Q. Now let's first talk about those one by one.
A. Okay.
Q. What was the role of the call center?
A. Again, to resolve telephone and written inquiries from any type of provider. If it was a hospital, physician, ancillary provider, DME, any type of provider, that inquiry would come into that department to be resolved.
Q. What sort of inquiries were coming in?
A. All kinds of inquiries, inquiries about "Is this individual a covered member?", questions about, you know, "This claim paid at this level. I would have expected it to pay at a different level. Can you explain to me why?", claim overpayments, any type of -- even a claim that hadn't been resolved yet, that call would come in.
So if a provider had submitted a claim and hadn't heard or received payment yet, they would call my area for status and say, "Do you know what

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the status is?"
Q. Did providers ever write in as opposed to calling in?
A. They did.
Q. And if they wrote in, did those letters come to the same group that ran the call center?
A. It came to a -- it came to a different group within the call center. There was a dedicated correspondence team.
Q. Okay. Was the correspondence team tasked with both hard copy correspondence as well as electronic correspondence with providers?
A. Mainly -- mainly hard copy. They recently are doing some electronic communications, but the vast majority is hard copy.
Q. Okay. Earlier in relation to one of your previous positions I had asked you about queries or calls from providers regarding the amount of reimbursement they were getting --
A. Uh-huh.
Q. -- in relation to particular services or drugs. Did this call center or the correspondence

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team deal with queries or concerns of that kind?
A. Absolutely.
Q. What sort of queries or concerns would they receive in that regard?
A. They would get a call, and a provider would say, "I got reimbursed $90 on this claim. I think I should have been reimbursed $95. Can you explain to me why this particular line item was disallowed?", or "The claim rejected in total. I don't understand why it rejected. Can you please explain to me this reject message?"
Q. Okay. Anything else?
A. Oh, a thousand different reasons, but...
Q. Now, similar to a distinction that I drew earlier, do I understand correctly that one set of complaints would be about how a particular claim was processed, whether a line item was disallowed, whether it should be properly processed under one code versus another, and that was a number of the queries that were received, right?
A. Correct.
Q. Now, separately did you receive queries,

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calls, concerns about the amount of reimbursement that was specified in the system, in the fee schedules for particular services or drugs?
A. No. I want to make sure I'm clear on this. If they were asking -- if a provider was calling saying, "I don't like the fact that I only get $25 for Procedure Code 99111," they wouldn't call my area on that.
Q. Okay. And let's take a drug-specific example. Let's say a provider had a concern over the amount he was reimbursed for a particular drug that he administered to a patient in his office, say, for example, he was concerned about the reimbursement not covering his cost for the drug. Would that be something that he would contact the call center or the correspondence team about?
A. He would.
MR. COCO: Objection.
A. He would.
Q. Is that -- are those types of issues, queries, concerns things that you dealt with in your role as the VP of provider enrollment and services?

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A. No. They are things my staff dealt with.
Q. Were queries of that kind received by your staff?
A. I have no specific knowledge of those queries being received.
Q. Okay. Have you ever heard of, anecdotally, such inquiries or issues being raised by providers?
A. Not specifically. Not specifically. But, again, providers call every day. I get $10,000 calls a day where providers are unhappy about something about a claim. I can't tell you what they're calling about.
Q. Okay. When these -- in the '98-2002 time period when you were working on consolidating these various services, was there a system in place already for logging or memorializing the content of calls received from providers?
A. Back in 1995 through 1998?
Q. Well, '98 -- I was thinking '98 to '02 when you were the VP of provider enrollment --
A. Yes, there were -- yes, yes, there was a

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contact reporting system in place.
Q. Okay. Now, prior to your coming on board as the VP of provider enrollment and services, do you know whether there was a system in place?
A. I do not know whether there was a system in place.
Q. Okay. After you came on board as the VP, what system was in place?
A. We developed a call recording system, or purchased a call recording system.
Q. Okay. Were all calls recorded?
A. I believe yes, yes, all calls were recorded, and we would sample from those calls for quality assurance purposes.
Q. Other than maintaining audio recordings, was there any system whereby the contents of these calls were written down in memos, in an electronic system, in a database? Was there any sort of data entry that ran along with the calls?
MR. COCO: Objection.
A. I would say there was some reporting that came out of -- but no -- you know, the kind of

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reporting that would come out of the system would be we got -- today we got 2400 eligibility calls. It wouldn't say of those 2400 eligibility calls here's a listing of each call and, you know, why each person was calling, but it would just aggregate up.
So there was a simple phone ticking system that would allow an associate at the end of the call to categorize the call, to say what type of call was this, was it regarding claim status, was it regarding claim benefits and eligibility? And we had about seven or eight different categories of claims --
Q. Was there --
A. -- inquiries, rather.
Q. Was there another miscellaneous category?
A. There was no way to deal with it on the phone system.
Q. Okay. So there was no space in that system for a free text entry?
A. No.
Q. Okay.
A. No. Again, I want to make sure I'm clear

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on the time frame. What time frame are you referring about the free text?
Q. Okay. Well, my understanding is prior to 1998 you don't know what systems were in place, if any, right?
A. Correct.
Q. Okay. So I'm talking now about '98 to 2002 when you were the VP --
A. Okay.
Q. -- of provider enrollment services?
A. Right.
Q. Do I understand correctly that during this time period the system allowed an associate to check one of seven or eight boxes --
A. Correct.
Q. -- regarding the general subject?
A. Correct.
Q. And there was no area for text entry to describe the substance of the call?
A. Correct.
Q. Okay. Do you recall what all of the categories were?

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A. I do not.
Q. Okay. Other than the ones that you've just mentioned, do you recall any other categories?
A. Claim status, adjustment. I think eligibility and benefits were two separate categories, and there may -- those are the ones I can remember.
Q. Okay. Other than the checked box system regarding the general subject area and the audio recording, was there any other record kept or report generated regarding the types of issues that physicians were calling about?
A. I don't believe so at this time -- at that time.
Q. Okay. Now let's go beyond the 2002 time period. In your current position do I recall correctly that you continue to be responsible for the call center?
A. I do.
Q. Okay. Has the technology used for memorializing the substance of calls changed?
A. (No verbal response.)

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Q. And for the court reporter you have to answer verbally.
A. I'm waiting for you to finish the question. I haven't heard the question.
Q. That's my question. Has the technology --
A. Oh, has --
Q. -- changed?
A. Has it changed? Yes, it has changed.
Q. Okay. When did it change?
A. I do not know.
Q. Was it sometime after 2002?
A. I would suspect, yes, sometime after 2002.
Q. What was the change that took place?
A. We enhanced the call recording capabilities to be able to capture additional data about each call. So to your earlier comment there's some type of -- there's an area for an associate to indicate some type of comments on a call.
Q. Okay. Is this system or database -- does it go by any particular name or designation?
A. Today we call it Blue Serve Connect. I don't know -- it's probably had several iterations

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of names. It may have been -- I think it was LUCI at one point, L-U-C-I, but it's now -- we've migrated to Blue Serve Connect.
Q. Can you describe for me, please, the system that has been implemented that is currently in place from the perspective of an associate who's dealing with a provider call?
A. Okay. As there are -- as they're initiating a call they create an open item or work item as they're handling the call, and as they are helping the customer they indicate something in this Blue Serve Connect database that helps us identify trends, you know, what types of call, claim status, but also provides for the capability to put some comments fields in there as well, and I believe perhaps the ability -- I think it also includes the ability to route a piece of work to -- a worksheet to another associate.
Q. In what circumstances would they need to route a call to another associate?
A. If they weren't able to adjust that claim, if it was beyond their scope of knowledge.

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Q. Now, leaving aside for a moment the free text field for comments, what are the other fields that associates do deal with? First let me ask you, structurally are these check boxes, drop-down menus or something else?
A. I believe it's drop-down menu.
Q. Okay. And do you know how many drop-down menus an associate fills in for each call?
A. I have no idea.
Q. Okay. Do you know generally what the -- what are the subject areas that are encompassed by the drop-down menus?
A. Generally, I think it's the type of product that the provider is -- obviously captures the provider that's calling so we know who called.
Q. Is the provider ID a drop-down menu?
A. No, the provider is actually asked to enter that before they get into the call system.
Q. Okay.
A. So when they're waiting in queue, it prompts them to enter their provider number so that when an associate gets presented with that call, it

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already has that information populated.
Q. Okay. I'm sorry I interrupted you. You were describing the types of information provided by drop-down menus?
A. I'm trying to think. Drop-down, where did I leave off?
Q. Type of product.
A. Oh, type of product, type of inquiry that if there were specifics regarding, you know, a particular patient or number of patients, they would indicate those, this is a call regarding eligibility for John Doe, member No. 12345 type of thing. And, again, there's a categorization box that says, you know, what type of inquiry is this? Is it eligibility, benefits, call status, whatever? And then there's a comments area.
Q. Do you know how much free text the comments area permits?
A. I have no idea.
Q. Okay. Do you know with what frequency the comments area is actually filled out?
A. I have no idea.

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Q. Does the system permit a search across the comment areas?
A. I have no idea.
Q. Okay. Who would know the answer to that question?
A. One of my technical staff.
Q. Anyone in particular?
A. Probably Steve Akeley.
Q. And what is Mr. Akeley's position?
A. He is director of provider services.
MR. MANGI: And for the record, we'll memorialize this in writing per request, but we would seek the answer to the question of whether the comments field can be text-searched.
Q. When we started talking about the call center, we began from a position of talking about what were the poorly performing areas that you were working on improving. What were the problems with the call center at the time that you became VP of provider enrollment and services?
A. The most significant problems were just poor service levels, poorly organized work flows,

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again, lack of adherence to established targets that we had, internal targets that we had established.
Q. What did you do to remedy these problems?
A. We essentially replaced the entire leadership team. We instituted a number of controls and reports, inventories, more closely monitoring staff as to what was going on, and we also added staff to this area as well.
Q. What are you referring to when you talk about adding reports?
A. I'm sorry, adding -- what I mean when I referred to adding reports?
Q. Right.
A. Creating reports to manage the inventories. The reports may have existed in the past, no one was using them, so we changed work flows so that front line leaders were getting TPS-type reports, that they were able to then monitor what was going on in the departments and evaluate, you know, who was really performing and who wasn't.
Q. Did those reports deal with work flow and resource allocation as opposed to the substance of

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calls and things of that kind?
A. It was the former, yes.
Q. Okay.
A. We also implemented some call center reporting capabilities, and it's really call center forecasting capabilities, software tools that allow you to better manage resources in a call center environment. We -- so that you can basically predict every half hour of every day how many calls you're going to get in each area and what your staffing needs need to be in that area.
We also -- I just had it here. I lost the thought. Sorry. It'll come back to me.
Q. Okay. Now, the second area that you mentioned that had been poorly performing and --
A. Uh-huh.
Q. -- calls for credentialing, what were the issues around credentialing?
A. It was an area -- the problems between credentialing are very much so similar to the problems that we had in provider enrollment, so this third area that we're going to talk about, the

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problems were very similar, again, poorly organized work flow, horrific service levels, not good service levels, poorly managed staff, poorly documented work flows, as a matter of fact, in some cases circular work flows, so pieces would just move around from one desk to the next without ever being resolved.

Q. Okay. And did those same -- do I understand correctly that those same problems also afflicted the provider enrollment area?

A. Correct. Correct.

Q. Now, what was the provider enrollment area? What does that --

A. Entail?

Q. Yeah.

A. They're responsible -- they work very closely with the credentialing area. When a provider sends -- providers generally send in a couple of kinds of maintenance to us throughout the course of the year. If they're a new provider, they send us contract work that allows us to set them up in the system, identify what their specialty is, PCP, whatever, link them to the appropriate group,

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that group structure that they belong to, and also work with the credentialing team to make sure that they have been properly credentialed so that they can treat patients.

Q. Is this a logistical section that deals with what happens after a provider has joined the network as opposed to having to do with how many people should be in a network and enrolling people in the network?

A. Correct. It's the latter. It's after provider contracting and provider relations have negotiated with the group or negotiated with an individual physician to join the network, that's when that contract would come into my provider enrollment area who would review the contract, make sure everything's appropriate, then begin to set that provider up on a provider file.

Q. Does provider enrollment play any role in identifying areas where the network is insufficient or where more physicians are needed?

A. Provider enrollment does not. Network -- provider relations does.

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Q. When you were the VP of provider enrollment and services, did provider relations fall within your areas of responsibility?

A. No.

Q. In your current role does provider relations fall within?

A. Correct.

Q. We'll come to that in a minute.

A. Yeah. The thought I lost before -- I want to just finish the thought on credentialing. The other issue that we had was we engaged a consultant to help us redesign the work flows.

Q. Who was the consultant?

A. A consulting firm called SCA. I couldn't tell you what SCA stands for.

Q. Okay. Now, other than dealing with the call center credentialing and provider enrollment, did you have any other responsibility as the VP of provider enrollment and services?

A. I did not.

Q. Now, you said that in addition to improving service levels in these areas, you also

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had a consolidation goal as VP of provider enrollment and services. What was that consolidation goal?

A. It was what we just spoke of. It was consolidating provider enrollment and credentialing and provider services all in one organization. Previously they had been -- those three activities resided in three different areas of the company, and no one individual was accountable for the whole process.

Q. And in the new structure you as the VP were accountable for the entire process?

A. Correct. And we relocated all of that operation to Rockland.

Q. Is that a -- was that a new venue or new office space?

A. We -- yes, we had a -- we relocated -- we previously had Rockland servicing the sales team, and we moved the sales team out of Rockland and moved the provider enrollment and services division folks in there.

Q. Was anyone else housed in that same site

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other than the group you were responsible for?
A. Yes, FEP is also housed in that space.
Q. And that's the Federal Employees Program we spoke about --
A. Correct.
Q. -- earlier?
A. Correct.
Q. How many people work for that program?
A. The FEP program?
Q. Yeah.
A. Currently there are probably 90, maybe 90 to 100 associates in that area.
Q. I believe you told me this already, but to save me looking through my notes who was the person in charge of the FEP?
A. Deborah Maroney.
Q. That's right. And she's a VP, correct?
A. No. I believe she's a director of FEP.
Q. Do you know, what are the -- what's the organizational structure into which these 90 to 100 associates are divided?
A. I do not.

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Q. How many people work for the provider services and enrollment group?
A. Currently we have probably about 330, 335 associates in the Rockland operation, just provider enrollment and services.
Q. Is anyone housed in that facility other than provider enrollment and services and FEP?
A. Yes. Yes. There's one small group -- actually, two additional groups are in there. There's a pharmacy operations group, and there's also a provider relations team that's housed in that space.
Q. What does the pharmacy operations group do?
A. My sense is -- again, I'm not close to it. My sense is I believe they mainly are there to deal with calls -- again, it's my understanding that they are there to handle calls for prior authorization drugs, drugs that require step therapy paperwork. I think any type of drug that requires some type of prior authorization or approval I believe is treated in that team.

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Q. And there's also a provider relations team based there?
A. There's also a provider relations team based there.
Q. Is that a team that deals with physicians or hospitals?
A. It deals with physicians and hospitals.
Q. Now, is there any sort of interaction between the various departments that are housed in this facility?
MR. COCO: Objection.
A. Yeah, I would have to say -- yes, there is interaction between some of these departments --
Q. Okay.
A. -- some departments more than others.
Q. Okay. What sort of interaction takes place?
A. For example, the provider relations team that's there represents -- it's the team representing the southern part of Massachusetts, and in the course of doing their work, you know, they may become aware of issues or problems that they

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would then communicate to the provider services team and ask them to research further. Also, there's a relationship between the provider services team and the FEP staff in that the FEP provider servicing components are handled within the provider services organization.
THE VIDEOGRAPHER: Five minutes left on tape.
Q. What do you mean by the last part of what you just said?
A. So that -- so there's a team of I'm going to say maybe 10 to 12 FEP provider service associates that do not physically -- are not physically aligned or are not organizationally aligned with the FEP team, Deb Maroney's area. There's a pod of FEP provider service associates that report into my organization that have a dotted line reporting matrix relationship to FEP.
Q. In other words, they're a provider -- I'm sorry, are those provider relations people or provider service people?
A. Provider service people, provider service

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people.
Q. So do --
A. So --
Q. Go ahead.
A. They'd be -- associates would be taking phone calls from FEP -- from providers regarding FEP members or FEP questions. They would take those calls.
Q. And what about provider relations people; does FEP have its own provider relations staff?
A. I don't believe they do. I don't believe they do. I think if there were a -- if there were an FEP issue that a provider would raise, it would be raised to their provider relations staff.
Q. Is the provider relations team that's housed in the Rockland facility tasked with responsibility for the FEP physicians as well?
MR. COCO: Objection.
A. They would be responsible for any type of provider inquiry.
Q. Okay. So that could --
A. So they service -- they service a provider

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regardless of the issue. They don't make a distinction and say, "You can't ask me that question because you're -- that's an FEP question." They'll take that question back -- they may hand it off to the FEP team for further work, but they'll be -- they'll be responsible for intake of that issue.
MR. MANGI: This is a good time to break so the videographer can change his tape.
THE WITNESS: Sure.
THE VIDEOGRAPHER: The time is 11:39. This is the end of Cassette No. 1. We are off the record.
(Recess taken.)
THE VIDEOGRAPHER: The time is 11:51. This is the beginning of Cassette No. 2 in the deposition of Vincent Plourde. We are on the record.
BY MR. MANGI:
Q. Slowly but surely we have made our way up to your present position, which is the VP for the provider services division?
A. Division, correct.
Q. Now, you've held this position since 2002,

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correct?
A. Correct.
Q. Okay. Now, I'd asked you earlier to itemize your responsibilities. I made a list, and I would like to ask you about some of those areas.
A. Sure.
Q. You mentioned that one of your tasks is to oversee the telephone and written inquiries from providers. That's the same call center and correspondence team you've spoken about, right?
A. Correct.
Q. In your current role do you have any responsibilities in relation to that group other than what we've already discussed?
A. No.
Q. And the second area you mentioned is dealing with claims that need adjusting. What did you mean by that?
A. That is an activity that's performed in the provider services area. So as a result of phone calls or written correspondence, it may be necessary to adjust a claim.

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Q. So going back to what we spoke about earlier, if a provider says that his claim was processed under one code and should have been another, if BC/BS agrees, then that's when this claims adjusting function comes into play?
A. Correct.
Q. Okay. So it's a support role that comes into play when responding to provider queries?
A. Correct.
Q. Credentialing is another area we've already spoken about. Do you have any responsibilities in relation to that area other than what we've discussed?
A. No, I can't think of any.
Q. Now, the fourth area you mentioned is provider file maintenance. What did you mean by that?
A. It's actually provider enrollment, was the area, and part of the activity in that task is to maintain the provider file data.
Q. Now, is this similar to the provider enrollment work that we've already discussed?

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A. Correct.
Q. And similar to that work, is this all after determinations have been made by contracting as to areas of network deficiency, who should be contracted with and so on?
A. Correct.
Q. In other words, after a contract has been signed, that's when your department becomes responsible for maintaining the file?
A. Correct.
Q. Now, the -- what is contained in the actual provider files?
A. All kinds of data regarding that provider, things like provider name, provider billing address, where he or she would like payments remitted to, if they're a specialist, what type of specialist are they, that kind of information.
Q. Are these physical files, or are these electronic files?
A. Electronic files.
Q. Now, are they maintained on some sort of a database?

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A. They are.
Q. Okay. What's that database called?
A. There are multiple databases. Huron is the primary database, and PNS is a separate database.
Q. What does PNS stand for?
A. Provider Network System.
Q. What's the division of labor between Huron and PNS?
A. I have no idea.
Q. Do the provider files contain any information regarding calls a provider may have made to the call center?
A. They do not.
Q. If a provider sends in written correspondence rather than calling in, is that correspondence then kept in that provider's file?
A. No.
Q. Where is the written correspondence stored?
A. It is stored in a paper file for a period of time before it's destroyed.

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Q. Is that scanned or imaged in any way?
A. It is imaged.
Q. Is that correspondence electronically searchable?
A. Yes, it is searchable.
Q. What about responses to the written correspondence; if a provider writes in rather than calls in, does the correspondence team then send a written response?
A. They do.
Q. Are those responses also maintained with -- filed with the provider correspondence?
A. They're filed with the original correspondence piece.
Q. So both the provider's letter and the response are filed together, imaged and electronically searchable?
A. Correct.
MR. COCO: Objection.
Q. Where are these, the correspondence and the responses, electronically maintained? Are they on a database of some kind?

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A. They are.
Q. Okay. Does that database have a name?
A. I do not know. I -- I don't know. I'm sure it does.
Q. Who is familiar with or deals with that database?
MR. COCO: Objection.
A. People in the provider enrollment area. I think the name of the system might be VIPS.
Q. V-I-P-S?
A. I believe.
Q. Do you know of a particular person in provider enrollment who's knowledgeable regarding the VIPS system?
A. I'm sure there are several people that are knowledgeable. I don't know a point person, but several people are knowledgeable about that system.
Q. Okay. Can you name any particular people that come to mind?
A. I honestly can't.
Q. Now, the fifth area that you mentioned was provider audit teams. Now, what are provider audit

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teams?
A. They're actually -- it's actually a hospital audit team, and what they do is they do chart reviews based on inpatient claims -- I'm sorry, inpatient and outpatient claims. They do chart reviews and go out on-site, pull the records and then see what the claim was actually billed for.
Q. What do you mean when you say they see what the claim was billed for?
A. They look at the chart and see what services were documented in that chart, what services were rendered, and then they look at the bill that the provider -- that the hospital submitted to us and say do these -- do these services in fact tie back to the charges that we were submitted?
Q. So they cross-check the actual medical records against the submitted claim to ensure they are consistent?
A. I wouldn't say medical records, I would say chart. They look at the billing chart that's prepared.

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Q. Can you help me understand -- I'm trying to understand the types of documents that they are looking at. What is the billing chart, and is it something distinct from the medical records?
A. It is.
Q. Okay.
A. It is. It's basically an amalgamation of all of their itemized records, all of their itemized bills that result in the production of a claim.
Q. And where is that billing record maintained?
A. At the hospital.
Q. Do the provider audit teams go out to the hospitals to carry out these audits?
A. They do.
Q. How many audit teams does BC/BS of Massachusetts currently have?
A. I do not know.
Q. Do you know how many people work in the provider audit area?
A. In my area, I would say probably about 20 associates.

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Q. Do they deal exclusively with hospitals, or do they also deal with physician offices?
A. They do -- they deal primarily with hospital. They currently don't do any physician. They do look at DME providers as well.
Q. Are there any groups within BC/BS of Massachusetts that do audit physician groups?
A. Yes, I believe there are.
Q. What department are those teams housed within?
A. They would be housed in the law department.
Q. Is there a particular person or group in charge of those efforts?
A. I'm guessing it might be Steve Skwara.
MR. MANGI: Would you like to be sworn, Mr. Skwara?
Q. The hospital audit team that we have been talking about, how long have these teams been in existence?
A. I don't know.
Q. When's the earliest time period when

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you're aware of hospital audit teams being in existence?
A. I would say I probably became aware of the fact that there was this team in 2000.
Q. Okay. Let me show you a document.
(Exhibit Plourde 001, Document headed "Non-Fee Services Comparison," marked for identification.)
Q. And if you would take a look at this document, please, which has been marked as Exhibit Plourde 001, and let me know when you're ready to proceed.
(Witness reviews document.)
Q. Have you ever seen this document before?
A. I have not.
Q. The footer of this document states on each page "The Professional Audit Department"?
A. Correct.
Q. Are you familiar with a department by that name?
A. I'm guessing that is the -- what I referred to today as the hospital audit department.

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Q. Okay. So this would be something generated by the provider audit teams that we've been talking about?
MR. COCO: Objection.
A. Correct.
Q. Now, I understand you haven't seen this particular document before. Have you seen documents of this kind, of this type?
A. I have not.
Q. Okay. On the first page of this document there's some references -- if you look at the first example, South Shore Hospital, in the table under "S/W Carl Holland Director of Reimbursement" there are entries for "Mark-up," "General Drug Services," "Acquisition times 3" and so on.
Do you have an understanding as to what this is referring to?
MR. COCO: Objection.
A. I do not.
Q. Okay. Do you know what S/W stands for?
A. I do not.
Q. Turning to the next page of this document,

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you see there are columns in relation to Milton Hospital, which is the first example there, particular drugs, "99 Red Book AWP" and then "Acquisition," which is -- in parentheses under that is "99AWP minus 35 percent," and there's "Mark-Up."
Are you familiar with any analyses of this type that have been performed by the audit teams?
A. I am not.
Q. Who would have been in charge of the audit function for hospitals around the time this document was generated in the fall of 1999?
A. I believe it reported in to Kim Olson.
Q. And what was Ms. Olson's title at that time?
A. It was either director or vice president of pharmacy operations, perhaps. I'm not sure of her exact title.
Q. Are you aware of any work by the audit teams that now report in to you that assess the prices that hospitals pay to acquire drugs?
A. I am not.
Q. Okay. Do you know whether the audit teams

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have access to information about drug acquisition when they carry out audits at hospitals?
A. I do not.
Q. Leaving aside the work of the audit team specifically, do you have any understanding, as you sit here today, as to the prices that different entities in the market pay to acquire drugs?
A. I do not have knowledge about what entities pay for drugs, no.
Q. Do you know, for example, whether or not there are discounts and rebates that are available to different entities on their drug purchases?
A. I have heard that there are deduct -- that there are rebates and discounts.
Q. Okay. In what context -- withdraw that.
Which entities are you aware of who can get discounts and rebates in the market on their purchases?
A. Generally providers.
Q. And by "providers" you're referring to hospitals and physicians?
A. Correct.

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Q. What's the basis for your understanding that there are discounts and rebates available to providers?
A. The fact that in the -- in my days in Medex we outsourced drug claim processing to a vendor, a PBM, and the basis of that decision to outsource those claims was in part due to the fact that they, the PBM, could get a better price on those drugs off of the AWP price.
Q. Now, going back to your Medex days, what was the -- in what context was BC/BS of Massachusetts -- well, withdraw that.
Was BC/BS of Massachusetts actually purchasing drugs either directly or then through this PBM?
MR. COCO: Objection.
A. I do not believe so.
Q. Okay. So what was -- what relevance did it have to Medex's business that PBMs can get rebates and discounts on drug purchases?
A. They would have -- they, the PBM, would have a contract with pharmacies and providers where

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they would apply these discounts. So if a provider wanted to be part of this net -- of the PCS network, which was the vendor at the time, then they had to accept the terms of that contract.

Q. Now, your Medex time was -- could you remind me what the time period was when you were in charge of Medex?

A. 1991 through 1995.

Q. And when did you outsource some of this work to a PBM?

A. I'm not sure.

Q. Okay.

A. I would -- I would guess 1994.

Q. Do you know which PBM that was?

A. PCS.

Q. Okay. So in the early '90s you understood that PCS could get discounts and rebates on the rates it reimbursed for drugs?

MR. COCO: Objection.

A. Correct.

Q. Did you also understand that PCS could get rebates and discounts on drugs that it purchased,

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say, for its mail order division?

MR. COCO: Objection.

A. I don't have any specific knowledge about their mail order.

Q. Okay. But based on the fact that PCS as a PBM could get discounts and rebates, you also understood that other entities in the market like physicians and hospitals would be able to get discounts and rebates on drugs that they purchased?

MR. COCO: Objection.

A. I don't have any specific knowledge to that.

Q. Okay. Well, earlier you mentioned that when -- that you understand that providers can get discounts and rebates on drugs. I'm trying to understand your basis for that knowledge.

A. The statement I made that PCS, the PBM vendor that we worked with, was able to deliver to us a price less than AWP.

Q. Okay. Do I understand correctly that in that '91 to '95 time period you understood that providers can also get discounts and rebates on

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their drug acquisitions?

MR. COCO: Objection.

A. I do not know. I did not know that they could get, no. I know we got a discount.

Q. Okay. Well, here's what I'm trying to understand. Did I understand correctly your earlier testimony that today, as you sit here now, you do understand that providers can get rebates and discounts on drug purchases?

A. I do.

MR. COCO: Objection.

Q. Okay. How long have you been aware of that fact?

A. Maybe a year.

Q. Okay. How did you come by that knowledge?

A. Just reading information in journals, Web stories, you know.

Q. Okay. What sort of stories or journals are you thinking of?

A. Just the fact that there are these, you know, discounts available.

Q. Now, is it your understanding that the

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discounts and rebates that are available to hospitals and physicians are all -- are uniform, there's a particular discount or a particular rebate available across the board, or do you understand there to be variable rates of discounts and rebates?

A. My understanding would be that there are variable discounts.

Q. Okay. Is it your understanding that those rebates and discounts fall within a particular range or a particular band or that they vary widely?

MR. COCO: Objection.

A. I do not have a particular percentage in mind.

Q. Okay. So you have no particular expectation as to what the range of discounts and rebates would be, although you know that rebates and discounts exist?

A. Correct. Correct.

Q. Are there any particular journals or stories that you've read that you are thinking of?

A. No, just different Web services that I subscribe to, i-Health Beat, different trade

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journals, that type of thing.
Q. Do you view the existence of those rebates and discounts and the fact that they are variable as being relevant in any way to your work as VP of the provider services division?
A. No.
Q. Do you view the existence of those variable rebates and discounts as being relevant in any way to what amounts BC/BS reimburses or should reimburse for drugs?
MR. COCO: Objection.
A. I would say yes.
Q. Okay. In what sense would you consider them relevant?
A. I think that we should have a common agreement of what those re -- what those true costs for those drugs are.
Q. Now, given that you've been aware of the existence of discounts and rebates for about a year, what steps, if any, have you taken towards acting on those -- on that knowledge?
A. None.

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Q. And why haven't you taken any steps towards acting on that knowledge?
A. I don't negotiate contracts.
Q. Well, if I understood your view correctly, you think the existence of those rebates and discounts is something that the contracting department should consider and act on, correct?
A. Correct.
Q. Have you communicated the information you've gathered to the contracting department and asked them to act on it?
A. I have not.
Q. Why not?
A. My understanding is that they're generally aware. They know more about this provider contracting industry than I do.
Q. Do you have any specific knowledge as to their awareness of, say, rebates and discounts in the market?
A. I do not.
Q. Have you had any discussions with anyone in contracting regarding your knowledge of rebates

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and discounts?
A. I have not.
Q. Do you know whether the contracting department has taken any steps or considered taking any steps stemming from the existence of rebates or discounts in the marketplace?
A. I do not know of any specific actions they've taken, no.
Q. Are you aware of any specific actions they've contemplated?
MR. COCO: Objection.
A. I can't think of any off the top of my head.
Q. Are you aware that in the 2004 time period BC/BS of Massachusetts contemplated moving from an AWP-based reimbursement methodology to physicians for drugs administered in office to an ASP-based methodology?
A. I am not aware.
Q. Now, you're a member of the provider financial strategies work group, correct?
A. I do participate.

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Q. Okay. Now, I've seen a number of minutes from meetings of that work group, and I mean no aspersion when I ask, you appear to be listed as absent from a number of those meetings.
A. Correct.
Q. Is there a reason for that?
A. The person who represents me on that group is Steve Fox. I attend periodically.
Q. Now, does Mr. Fox report in to you?
A. He does.
Q. So although you're formally a member of that group, when Mr. Fox attends, you generally do not attend; is that accurate?
A. No, that's not accurate.
Q. Okay. What is the determining factor as to whether or not you will attend?
A. Whether or not my schedule allows.
Q. What proportion of meetings of the provider financial strategies work group do you attend?
A. I would say maybe 30 percent.
Q. And at the remainder of those meetings

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you're represented by Mr. Fox?
A. Correct.
Q. Now, going back to the Exhibit Plourde 001 that we looked at earlier, on the second page of it there was a reference to Red Book, the 1999 Red Book AWP. And do you know what the Red Book is?
A. I do not.
Q. Are you familiar with First DataBank or Medispan?
A. I have heard the terms "First DataBank" and "Medispan." I do not know what they are.
Q. Now, that is -- document is listing the AWPs for drugs in 1999. How long -- when's the first time that you heard the term "AWP" used?
A. I would say it was around that time frame when we outsourced drug processing to the PBM, and I learned that they were able to negotiate a rate less than AWP on pharmacy claims.
Q. So you understood that they would reimburse at AWP minus a certain percentage --
A. That I -- yes.
Q. So you understood that AWP was a benchmark

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that they used in negotiating a discount off that would then serve as the reimbursement rate?
MR. COCO: Objection.
A. That's what the PBM used as a benchmark.
Q. Okay. Now, what was your understanding at that time as to what, if anything, AWP actually represented or was?
MR. COCO: Objection.
A. I really didn't have a good understanding of what AWP was. I was familiar with the term, but I couldn't tell you what it was composed of.
Q. Okay. So your only understanding of it was as a benchmark used by the PBM in negotiating a discount off of reimbursement?
A. Correct.
Q. Did you gain a better understanding as to what AWP is at any point after that?
A. No, not particularly.
Q. Okay. So as you sit here today, is your only knowledge about AWP that it's used as a benchmark in reimbursement for negotiating discounts?

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A. That it is.
Q. Are you familiar with the term "WAC" or "wholesale acquisition cost," W-A-C?
A. I have heard the term.
Q. When's the first time you heard that term?
A. Probably in the same time frame that we outsourced to PBM.
Q. What was your understanding of that term?
A. I know what the words mean, wholesale acquisition cost. You know, I have no -- can't tell you anything beyond that.
Q. Okay. In what context did WAC come up in relation to outsourcing work to the PBM?
A. It just would be used in different meetings when people were talking about pricing pharmacy claims. Someone would say, "Oh, it's a formula based off ASP," someone else would say, "It's a formula off WAC," so just two different benchmarks.
Q. Now, you just said ASP. Did you mean to say AWP?
A. AWP.

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Q. Okay. Was the methodology being expressed as either AWP minus a percentage or WAC plus a percentage?
A. I couldn't remember.
Q. Did you gain at that point an understanding as to what relationship there was, if any, between WAC and AWP?
A. I did not.
Q. Have you subsequently gained a better understanding as to what WAC is?
A. I have not.
Q. Have you subsequently gained a better understanding as to the relationship between WAC and AWP?
A. I have not.
Q. Have you gained at any point an understanding as to the relationship between WAC and actual drug acquisition costs paid by providers?
A. I have not.
Q. But you are now aware of the fact that there are rebates and discounts available?
MR. COCO: Objection.

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A. There are some, yes.
Q. Another issue that was discussed in the provider financial strategies work group was transitioning hospital outpatient departments from a percentage of bill charge methodology, and I'm talking now about drugs administered to patients in hospital outpatient departments. My sentence has become long, so let me start the question again.
Another issue that's been discussed in the provider financial strategies work group is transitioning hospital outpatient departments from a reimbursement methodology that uses percentage of bill charge in relation to drugs administered to members to a methodology that uses 95 percent of AWP. Are you familiar with that transition?
A. I have heard that term discussed. I'm not familiar with the outcome.
Q. Okay. When you say, "I've heard that term discussed," what term are you referring to?
A. What you just said, that we -- you know, taking a look at outpatient charges as today being adjudicated at a percent of charges and considering

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whether or not they should be instead reimbursed at some percentage of AWP.
Q. So you were saying that you're familiar with the issue, you weren't referring to any particular phrase that I used?
A. I'm familiar with the issue --
Q. Okay.
A. -- right.
Q. Okay. Did you participate in provider financial strategy work group meetings where that issue was discussed?
A. I may have been in attendance at meetings where that was discussed.
Q. Did you participate in any of the discussions regarding that transition?
A. I did not.
Q. Did you consider it at all relevant to those discussions that you are aware of the existence of rebates and discounts on drug acquisitions for providers?
MR. COCO: Objection.
A. I did not.

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Q. Okay. Why not?
A. I didn't see the connection.
Q. Well, if what was being contemplated was moving from a percentage of bill charges to an AWP-based methodology and you're aware of the fact that providers purchased drugs at a discount and get rebates off them, wouldn't you consider that relevant to a determination of whether or not an AWP methodology should be adopted?
MR. COCO: Objection.
A. I'm not following the question.
Q. Okay. In moving from a percentage of bill charges to an AWP-based methodology for hospital outpatient departments, did you consider it relevant to the issue what those hospital outpatient departments were actually paying to buy the drugs?
A. I did not.
Q. Now, another area that you mentioned responsibility for is e-Health initiatives?
A. Correct.
Q. Can you describe for me what that is about?

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A. It's essentially supporting a number of pilot programs to put new technologies out in the physician offices to help them improve the quality of care delivered to patients.
Q. And what sort of initiatives or technologies?
A. E-Prescribing -- we launched an e-Prescribing pilot. We launched a couple of EMR and Medical Decision Support pilots, those kinds of activities.
Q. And the seventh area you mentioned was working with provider support teams?
A. Correct.
Q. What are the provider support teams?
A. They're the folks that are responsible for making sure that providers are able to pass us HIPAA-compliant claims and make sure that as we begin the migration to this national provider identifier system, that we're able to process the claims and that the providers are able to get them to us.
Q. Is the focus of those teams primarily on

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HIPAA compliance, or are there other aspects to their work?
A. It's primarily HIPAA compliance, it's primarily HIPAA.
Q. Now, other than the seven specific areas we've just spoken about, do you have any other areas of responsibility as the VP for the provider services division?
A. The only other activity that we spoke of was the fact that I have a group of people that maintain the claim check tables.
Q. Okay. What are claim check tables?
A. Those are the tables that we mentioned earlier that are responsible for comparing claims to determine whether or not one service was incidental to another service, whether services are mutually exclusive, so on and so forth.
Q. Anything else?
A. No. That's...
Q. Now, are you familiar with specialty pharmacies?
A. I've heard the term "specialty

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pharmacies." I'm not familiar with them.
Q. Have you been involved at all in Blue Cross and Blue Shield of Massachusetts' contemplation of utilizing specialty pharmacies or in decisions about the parameters of specialty pharmacy programs that have been implemented?
A. I am not.
Q. Are you familiar at all with the BC65 product, Blue Care 65 product?
A. I am.
Q. Are you aware of any of the changes in reimbursement methodology that have been contemplated by BC/BS of Massachusetts in relation to that product?
A. I am not.
Q. Now, are you aware of what the reimbursement methodology is that's used for reimbursing physicians for drugs administered in office for members who carry the BC65 product?
MR. MANGI: I am not.
MR. COCO: Why don't we take a quick break. Off the record.

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THE VIDEOGRAPHER: The time is 12:28. We are off the record.
(Recess taken.)
THE VIDEOGRAPHER: Back on the record at 12:38.
BY MR. MANGI:
Q. Now, Mr. Plourde, in addition to the eight areas of responsibility that we've talked about that you have in your current position, Ms. Cook testified -- Ms. Jan Cook testified about your having another area that I would just like to confirm if she was right or not. She said that you were responsible for the provider managers who go out into the field and work with physicians. Is that accurate?
A. That is, and that's the provider relations activity.
Q. That's the provider support team you talked about --
A. No.
Q. -- is it?
A. Provider relations area.

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Q. Now, I don't have a provider relations area on my list. We talked about --
A. At one point -- we can certainly go back and --
Q. Sure. Was that part of the call center?
A. No. It was when I took on the new role, you asked me what additional accountabilities I took on. One of those additional accountabilities was the provider relations team. So in 2002 I maintained what I had with the provider enrollment and service division, but I added provider audit, the hospital audit team that I spoke about, I added the claim check staff that we spoke about, I added the provider support people that we spoke about, and I also picked up the provider relations and provider education team.
Q. Okay. Now, what is your responsibility of the provider relations team?
A. It's their job to work with physicians, office managers, hospitals, any hospital or physician provider other than ancillary or behavioral health, because there's a separate area

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that deals with those. Those people are out in the field working with them, sharing reports, educating them, answering questions.

Q. Now, are you aware of -- do all the provider relations team members report in to you?

A. No. They report in to different leaders who report in to Steve Fox, who reports in to me.

Q. Okay. Are you aware of any interactions between physicians and provider relations personnel where physicians have raised concerns or issues regarding the amount of reimbursement that they receive for drugs administered in their offices?

A. I am not.

Q. Any concerns relating to the reimbursement they receive for services incident to drug administration?

A. I am not.

Q. Are you aware of any concerns providers have raised in relation to the possible implementation of specialty pharmacy programs?

A. I am not.

Q. Are you aware of any concerns or issues

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providers have raised in relation to possible changes in reimbursement methodologies?

A. You need to be more specific.

Q. Okay. Are you aware of any concerns providers have raised in relation to changes in the reimbursement methodologies that are used to calculate the amounts reimbursed to them for drugs administered in their offices?

A. I am not.

Q. Okay. Now, do you know whether or not BC/BS of Massachusetts contracts with any drug manufactures?

A. I am not aware.

Q. Do you know whether or not BC/BS of Massachusetts receives any rebates from manufacturers in relation to formulary placement?

A. I am not aware.

Q. Are you familiar with Medicaid or government shortfall payments?

MR. COCO: Objection.

A. I am aware of the general concept from reading the Boston Globe that there are Medicare and

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Medicaid shortfalls, but that's the extent of my knowledge.

Q. What are the articles that you're referencing?

A. Articles that have appeared in the Boston Globe.

Q. Okay. And what did they say in relation to Medicare?

A. Their comments have been that there are shortfalls that providers are not able to cover the full cost of the care that's being provided to Medicaid and Medicare patients.

Q. And by "providers," does that include both physicians and hospitals?

MR. COCO: Objection.

A. I can't say when I read the article whether it was clear whether it treated them separately or differently.

Q. In what time period did you see the articles that you are referring to?

A. In the past year.

Q. Are you aware of any articles discussing

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those issues prior to the last year?

A. No.

Q. Are you familiar with the term "ASP"?

A. I'm familiar with a term "ASP."

Q. Okay. What is your understanding of ASP?

A. It stands -- my term, the recognition is it stands for average semi-private.

Q. Okay. What is average semi-private?

A. It's the rate that Blue Cross pays for an average semi-private room.

Q. Ah, okay.

MR. MANGI: Off the record.

(Discussion off the record.)

Q. Are you aware of any other ASPs other than average semi-private?

A. I became aware of the average sales price only in the context of preparation with my attorneys before the meeting, but prior to that I really hadn't -- ASP meant average semi-private in my world.

Q. Did the articles that you mentioned from the Globe discuss or deal with ASP, as far as you

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recall?
A. No.
Q. And by "ASP" in that context I'm referring to average sales price.
A. Correct. No.
Q. Other than your understanding of shortfalls in the context of that article -- those articles, are you aware that BC/BS of Massachusetts makes payments to hospitals at the present time that they refer to as either Medicaid shortfall payments or government shortfall payments?
A. I am not sure what that mechanism is, so I'm -- I'm aware that there's an uncompensated care pool, but I don't know if that's the mechanism that you are referring to.
Q. Okay. What is the uncompensated care pool?
A. It's a state assessment on all health plans to pay for the Medicaid and Medicare shortfalls, I believe. It's for bad debt, uncompensated care pool for bad debt.
Q. Is it your understanding that that's an

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amount that BC/BS of Massachusetts is obligated to pay to the state by law?
A. I believe it's by law.
Q. Okay. And your understanding is that's an amount that's paid to the state?
A. That's an amount paid to the state that the state administers a fund.
Q. Is that the only --
A. That's the only knowledge --
Q. -- that you're aware of?
A. -- that I have of that subject.
Q. Now, in 1994 you were working as director of the Medex --
A. Correct.
Q. -- Client Business Unit, correct?
A. Correct.
Q. Are you aware that in 1994 BC/BS of Massachusetts settled with the federal government allegations that the company had submitted false Medicare reports in processing Medicare claims?
A. I am aware of that.
Q. Now, were you aware of that at the time,

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or is that something you've learned about subsequently?
A. I was aware of that at the time.
Q. Okay. Can you describe for me what the issue was that was being addressed in this government investigation?
A. My understanding was the allegation was that correspondence documents were being inappropriately date-stamped so that they would appear that they were meeting turnaround standards that were prescribed by the Medicare program and in fact, you know, we were not achieving those turnaround standards.
Q. Anything else?
A. No.
Q. Okay. Is it your understanding that the allegations in that case were limited to date -- inappropriate date-stamping?
A. That was -- yes, that's my understanding, that it was -- I'm only aware of the date- stamping issue.
Q. Okay. And when the Department of Justice

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refers to "false Medicare reports," is it your understanding that those were inappropriately date-stamped?
A. Yes. There are turnaround time reports that had to be submitted to Medicare indicating how many claims or how many pieces of correspondence were resolved in a time frame, and those are the reports that they're referring to.
Q. Do you have an understanding as to what the outcome was of that investigation?
A. My understanding was that there was a settlement that was reached.
Q. And do you know what the terms of that settlement were?
A. I do not know the terms of that settlement. Let me correct -- I know -- I think part of that settlement required greater employee education around compliance activities, but other than that, I don't know what the specific terms of the deal were.
Q. Okay. I'm reading from a Department of Justice press release regarding the settlement which

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states that "The suit alleged that BC/BS misrepresented and inflated the number of claims and reviews it processed in periodic reports submitted to HCFA."

Now, is your understanding that that is inaccurate?

A. No, I believe --

MR. COCO: Objection.

A. I don't know what they're referring to. It's -- my understanding is what I shared with you, that they were claim inventory -- there were turnaround time reports that dates were manipulated with.

Q. Are you aware of any allegations regarding misrepresentation or inflations of numbers of claims in reviews submitted to the government?

A. I am not aware of that.

Q. Now, are you aware as part of the settlement BC/BS of Massachusetts agreed to hire more workers to detect and investigate allegations of fraud and abuse by Medicare providers?

A. I'm sure they did. I'm not specifically

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aware of those people being hired.

Q. Now, after your role as director of the Medex unit in 1995, you became -- you took on a claims role, didn't you?

A. Correct.

Q. What was your title in 1995?

A. Director of claims.

Q. That's right. As director of claims were you responsible for or familiar with any staff who had been hired pursuant to this settlement who were working on detecting or investigating allegations of fraud and abuse by Medicare providers?

A. Not to my knowledge.

MR. MANGI: Mr. Plourde, I have no further questions for you, but I believe my colleague may have a couple.

THE WITNESS: Sure.

CROSS EXAMINATION

BY MR. MIZELL:

Q. I have a few questions about the Medex Client Business Unit.

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A. Uh-huh.

Q. You mentioned there were various levels of coverage offered. Could you just explain some of the different products that were available? These are different Medigap policies?

A. These were different -- these were different Medigap policies. It was a Bronze product which was -- offered comprehensive coverage but did not offer a drug benefit. There was Medex Gold that offered a drug benefit that was the same program as Bronze, but it has the additional benefit of a drug benefit.

There were probably at one point probably eight or ten different variations of Medex products with different components. You know, one had a deductible, one didn't have a deductible, all variations of the same theme.

Q. Would participants in Blue Care 65, to the extent they wanted supplemental Medigap-type coverage, would they get a Medex product, or would they get a supplement on the Blue Care 65 side?

A. The Blue Care 65 is the Medicare

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supplement for HMO members. So they're -- Medex and Blue Care 65 are competing products, if you will.

Q. But they're both offered by Blue Cross/Blue Shield?

A. Correct.

Q. Did you -- while director of the Medex Client Business Unit did you gain any understanding of the factors that were considered in setting the premiums for these products?

A. I -- no, no, I was not involved in that.

Q. Who was involved?

A. Eleanor Socholitzky.

Q. That was who you reported to?

A. Correct.

Q. She was vice president of regulated products?

A. Correct.

Q. Okay. When you were the director of this Medex Client Business Unit, did you ever discuss with anyone in the department any expectations about margins that providers were -- providers might be earning, the difference between acquisition costs

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and reimbursement rates for drugs administered in the office?
A. No.
Q. Any conversations along those lines with anyone when you were director of the claims division?
A. No.
Q. Or in your current position?
A. No.
Q. Okay. In these three different roles you've had with Blue Cross/Blue Shield, have you ever had such an expectation about the margins that physicians might be earning on drugs administered in their offices?
A. No.
Q. So you never had an expectation that these margins might be the same for all physicians?
A. I had no idea, and I have no knowledge about it.
Q. Okay. Did you have an expectation that these margins would be uniform for all physicians for all drugs administered in their offices?

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A. I had no expectations.
Q. So you would have had no expectation that these margins would remain static over time for the same drug for the same doctor?
A. No knowledge on any of it.
Q. Okay.
A. Whether they were variable by doctor, fixed over time, again, beyond my scope.
Q. Okay. Not aware of any investigation into these physician margins by anybody at Blue Cross/Blue Shield?
A. No. No.
MR. MIZELL: Okay. That's all I have.
MR. COCO: No follow-up, so we're done.
THE VIDEOGRAPHER: The time is 12:55. This deposition is concluded. This is the end of Cassette 2. We are off the record.
(Whereupon the deposition was concluded at 12:55 p.m.)

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SIGNATURE OF WITNESS

_____
VINCENT D. PLOURDE

Subscribed and sworn to and before me this _____ day of _____, 20____.

_____
Notary Public

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United States District Court
For the District of Massachusetts

I, Jessica L. Williamson, Registered, Merit Reporter, Certified Realtime Reporter and Notary Public in and for the Commonwealth of Massachusetts, do hereby certify that VINCENT D. PLOURDE, the witness whose deposition is hereinbefore set forth, was duly sworn by me and that such deposition is a true record of the testimony given by the witness.

I further certify that I am neither related to or employed by any of the parties in or counsel to this action, nor am I financially interested in the outcome of this action.

In witness whereof, I have hereunto set my hand and seal this 19th day of April, 2006.

Jessica L. Williamson, RMR, RPR, CRR
Notary Public, CSR No. 138795
My commission expires: 12/18/2009